

## Medical Care Advisory Committee (MCAC)

Monday, January 11, 2021

**Members Present:** Lisa Adams, Mike Auerbach, Kathy Bates, Jake Berry, Sai Cherala, Lisa DiMartino, Tamme Dustin, Amy Girouard, Ellen Keith, Peter Marshall, Paula Minnehan, Kara Nickulas, Ken Norton, Ronnieann Rakoski, Bill Rider, Nancy Rollins, Karen Rosenberg, Jonathan Routhier, Mel Spierer, Kristine Stoddard, Carolyn Virtue, Michelle Winchester, Heather Young **Excused:** Sarah Morrison, Dr Marie Ramas

**DHHS:** Henry Lipman, Alyssa Cohen, Dr. Sarah Finne, Dr. Beth Daly, Dawn Landry, Jane Hybsch, Leslie Melby, Shirley Iacopino, Laura Ringelberg, Katja Fox, John Williams, Brian Clark

**Guests:** Senator Ruth Ward, Senator Bob Giuda, Nick Toumpas, Peter Janelle, Michelle Craig, Bill Gunn, Kevin Irwin, Katie Lipp, David Donohue, Lucy Hodder, Carol Iacopino, Nichole St. Hilaire, Susan Paschell, Deb Fournier, Deb Ritsey, Dan Courter, Jasmine Harris, Nick Colby, Audrey Gerkin, Rich Segal, Lauren LaRoche, Robert Clegg, Heidi Kroll, Carissa Kutz, Tory Jennison, Christine Alibrandi, Sara Gleysteen, Terry Olson, Annette Kurman, Pam Becker

Announcements, Carolyn Virtue, Chair

Case Management: The Chair read the following statement into the record:

At the December MCAC meeting Sandy Hunt, Bureau Chief of BDS responded to a member's question with a presentation, which did not fully answer the member's question.

On December 29th, Sandy Hunt convened an "MCAC Inquiry" Zoom meeting. Jonathan Routhier, Amy Giouard and I were present. The December 29th call created confusion and more questions surrounding the application of federal regulations and state plan requirements for the IHS Case Management. Sandy explained IHS Case Management is not governed by either the regulations or the state plan, it is governed only by the waiver.

There was discussion as to whether or not the IHS Waiver Case Management is a targeted service. The department's position was stated as the IHS case management service is NOT a targeted service.

In follow up to the ABOVE REPORT ON THE 12/29/20 MCAC Inquiry Meeting: I offer the following: GOOD NEWS! The IHS Waiver was approved by CMS last week.

Case Management is required to be a State Plan service and it is included in NH's Medicaid State Plan and the associated State Plan Amendments. Additionally, the service is defined by federal regulations which clearly spell out what case management is and is not. Case Management can be offered by a state as a targeted service or not. The only difference being the limiting of the service to a defined population. If this claim that IHS Case Management is NOT targeted is accepted as fact, the state must offer a comparable service for all of the Medicaid populations, NH does not currently do so. Case management, whether delivered to a targeted group or not, is defined as a service which is delivered by Medicaid enrolled providers which includes but is not limited to:

- comprehensive assessment
- determination of need
- advocacy
- care planning
- identification of goals and objectives
- identification of services, providers and referral.
- identifying social and community services and supports
- assuring participation of the individual or their health care proxy
- monitoring for status change and making required updates

Specifically in regard to the IHS waiver, I think it is important to recognize the valuable contribution of the parents of the children served. The parents are the most knowledgeable on their child's medical condition

and their child's needs. They are the very best advocates for their own children and they should be the primary voice and the final voice. I fully support the parents being the decision makers for their own children. However, for their own children they cannot be the medical provider of case management services. For staters, because a blood relation presents a prohibited conflict of interest. Families should however be given the choice to forgo the case management service if not needed because of their contributions.

It is important to note here NH has a provider rule for case management and the NH Bureau of Health Facilities licenses Case Management providers. The department's current plan for IHS Case Management under discussion is to enroll individuals who are NOT licensed providers to deliver case management services to IHS Waiver recipients. This plan is questionable at best and certainly warrants further discussion.

There are several members of the MCAC, myself included, who would very much like to work with the department toward developing a compliant case management system which ensures delivery of a quality service to the individuals we are charged with serving.

Deb Scheetz and Sandy Hunt are working on this issue and will address at a future meeting.

**Review/Approval: December 14, 2020 minutes.**

Motion: Amend minutes to add (1) the Chair asked DHHS to provide further clarification at the next meeting to respond to the question on IHS waiver case management; (2) the Chair will follow up with Sandy Hunt on specifics; (3) DLTSS would like to address this at a future meeting, as additional time is required to prepare. M/S/A. Minutes as amended: M/S/A

Jonathan Routhier, Chair, Membership Subcommittee announced that the subcommittee met to align Nancy Rollins's term with other members' terms (July 1 – June 30).

**Legislative Update, John Williams Esq, Director, Legislative Affairs**

The Senate is grouping bills by subject into omnibus bills. See [Revised LSR Combination List as Approved by the Senate Rules Committee](#). For instructions to the public on hearings, see [Senate Guidance for Remote Committee Meetings How to register support/opposition on a bill](#) (emailed to MCAC 1/15/21).

Some hearings may be held in person with social distancing. 400 bills have been published.

Bills specific to Medicaid were highlighted (see handout sent 1/11/21).

HB 103, *establishing a dental benefit under the state Medicaid program*. Similar to HB 1530 last year. The dental benefit will be considered as part of the budget bill.

HB 363, *creating a committee to study appointing an inspector general for nursing homes*.

LSR 210, *relative to including certain children and pregnant women in Medicaid children's health insurance program*. Details not available.

LSR 427: *Clarifying Medicaid spend-down requirements and requiring a report to the oversight committee*.

A similar bill (HB 739) was tabled last year re: behavioral health expenses to be included as medical expenses.

LSR 735, *relative to the physician-patient relationship and the exemption from licensure for physicians in other states and countries*. Addresses telehealth.

LSR 1046, *making an appropriation to DHHS for primary prevention services for families*.

LSR 208, *relative to nursing home standards*. The bill's sponsor, Senator Ruth Ward, stated that last year's bill, SB 671, failed for inability to regulate border states. Senator Ward's concern is that a patient will be sent to a substandard out-of-state facility because it costs less.

LSR 568, *relative to reimbursement for telemedicine*

LSR 724, *relative to privacy of personal information retained by a health or social service agency and prohibiting sharing of such information between such agencies*. Language is not yet available to evaluate impact.

### **DSRIP Annual Forum, Henry Lipman, Medicaid Director**

The waiver, ending 12/31/20, focused on integration of primary care and behavioral health, and coordination of care. Seven federally funded regions – Integrated Delivery Networks (IDN) – were established.

Earned incentive payments were made to IDNs based on process measures during the first 2½ years; and thereafter tied to performance measures. Each IDN participated in 2 statewide projects, 1 mandatory core competency project, and 3 community-driven projects. Funding was based on regional member attribution, process and performance measures, statewide and community-based projects, and identified metrics.

The [NH DSRIP Evaluation Interim Report](#) documents implementation processes and the State's progress toward meeting DSRIP goals. Results: the BH study population had more access to services than the non-BH population. Performance on most quality measures had not significantly changed between the pre-waiver period and the first 2 years of the waiver. The final report will capture work on integration of BH/SUD and primary care and coordination of care.

### **DSRIP Notable Achievements: Nick Toumpas, Jessica Liandri, Peter Janelle, IDN Administrative Leads**

Each IDN innovated based on individual region's priorities. Focus areas include:

- Integration supported by social determinants of health;
- Expanded capacity to deliver care in the most appropriate settings;
- Addressing gaps when a person transitions from one site of care to another

Integrated care is the foundation for DSRIP. Building relationships and actively collaborating with other entities is more important than ever.

- **Health Information Technology:** Focus on technology solutions to support integrated care. Implemented real time event notification system, electronic shared care plan, and statewide direct and secure messaging. There was great variation among partners.
- **Workforce:** The IDNs began with an assessment with the goal to enhance workforce capacity. Focus was on recruitment, staffing, retention, and training and professional development initiatives. Examples: partnering with AHEC to develop the health careers catalog; partnerships with colleges and universities with scholarships, certificate programs; and statewide roundtables to discuss employers' needs.

IDNs expanded medication assisted treatment (MAT); critical time intervention; communities of practice for community led interventions; and knowledge exchange to learn from other organizations.

- **Integration of primary and behavioral health:** Implemented standardized protocols across multidisciplinary providers for assessment, workflows, timely exchange of information; co-located primary care and behavioral health; collaborative care model; integrated care and enhanced care coordination between hospitals, SUD, FQHCs, CMHCs.

The IDN Administrative Leads will return to discuss community health workers and collaborative care legislation.

### **DHHS Website Redesign, Leslie Melby, Medicaid Special Projects Administrator**

Due to limited space to take part in website focus groups, MCAC was unable to participate. There may be an opportunity for stakeholders to review the website before it's finalized. If interested, contact L Melby.

Online archived documents will be determined by program areas and by mandates. All State websites follow ADA requirements, including a translation function, larger font, and links to equity and disability assistance. MCAC minutes no longer available online may be requested.

### **COVID Vaccine, Beth Daly, DrPH, Infectious Disease Control**

Two vaccines are currently available – Pfizer and Moderna; both are 95% effective. Side effects include swelling, fatigue, headache, etc., all signs that the body is responding. The rollout includes:

Phase 1a: highest risk health workers, first responders, residents and staff of long term care facilities.

Phase 1b: people age 75 and older; medically vulnerable with 2 or more conditions on CDC list; residents, staff of residential facilities for persons with intellectual and developmental disabilities; corrections staff.

Phase 2a: ages 65-74; Phase 2b: ages 50-64; Phase 3a: medically vulnerable under age 50 with one or more conditions. Phase 3b: all others.

The vaccination timeline is an estimate and therefore dependent on vaccine uptake and number of doses allocated to NH. HCBC workers fall under the home care category of those currently eligible for vaccination. Though persons at risk can be vaccinated, those providing “in kind” services to them do not qualify under Phase 1b. To date, 81,950 doses allocated to NH; as of Jan 11, 50,000 people vaccinated.

For information, the public is directed to: Call 211; Online <https://www.nh.gov/covid19>;

Email [covidvaccine@dhhs.nh.gov](mailto:covidvaccine@dhhs.nh.gov). PSAs are under development.

### **Department Updates, Henry Lipman, Medicaid Director**

- **Agency Budget, FY 2022/2023:** Awaiting for Governor’s budget to be finalized.
- **Redetermination and Eligibility.** The federal government extended the PHE to April 21, 2021. CMS provided guidance programs on how to prepare for the end of the PHE, to include the transfer of individuals into the right category of eligibility. Medicaid will work with MCAC on how it will work through the redetermination process. Additional information will be provided in February. DLTSS submitted a request to extend Appendix K. CMS allows Appendix K to operate six months beyond the end of PHE.

COVID vaccine: CMS requires a state plan amendment (SPA) to cover vaccine administration under Medicaid. The federal government pays for the cost of the vaccine. Medicaid does not cover vaccinations of the COVID testing group and family planning group. Other funding sources (HRSA) may be pursued.

- **MCM Amendment #5:** Submitted to G&C and hope to appear on the next G&C agenda.
- **Disability Determinations.** Data was sent to MCAC. To be discussed at February meeting.

### **Private Duty Nursing (PDN), Jane Hybsch, Medicaid Medical Services Administrator**

Under the 1135 waiver obtained in March, we found out we could allow family members who are screened to provide personal care services. There is a prohibition against paying family members for private duty nursing services; therefore a threshold of not more than 50% of unfilled PDN hours can be paid for personal care services to ensure we are meeting the compliance limitation. The MCOs are required to reach out to families to make sure they received the information and to answer any questions. The next group of letters will go out next week to families who have 50% or less hours of PDN services filled.

Appreciation was noted for M Winchester’s PDN brief; the NH federal delegation will be engaged in discussions as needed related thereto.

### **Adult Dental Benefit, Sarah Finne, DMD, Medicaid Dental Director**

Two bills have been filed that support the adult dental benefit. DHHS is awaiting word as to funding in the proposed budget.

### **Telehealth Rules, Dawn Landry, Medicaid Policy Administrator**

MCAC subcommittee and DHHS staff will have its first meeting January 21<sup>st</sup> to review JLCAR deadlines and to schedule future meetings.

**Rules Subcommittees, Carolyn Virtue, Chair**

**He-E 801:** Subcommittee members: M Winchester, Chair; N Rollins, E Edgerly, P Marshall, K Nickulas, C Steinberg, G Balkus, C Virtue. The subcommittee met late spring/early summer. The MCAC will receive the rule simultaneous to the filing at which time the subcommittee will reconvene.

**Committees with MCAC Representatives:**

HB 692 Adult Dental Work Group: L DiMartino, N Rollins. Alternates: A Girouard, C Virtue

Motion to adjourn: M/S/A